City of Houston Accident Report

1. Incident Type						
	Safety	☐ Property Damage	☐ Near Miss	☐ Incident Only	☐ First Aid	☐ Illness
	Workers' Compensation	☐ Medical ☐ Lost Time		☐ Fatality		Cost Center #

2. General Information

A. Name Of Injured Employee	B. Employee #	C. Social Security Number

D. Primary And Secondary Telephone Numbers For Employee Contact		E. Occupation of Injured Employee	F. Date/Time Of Injury
1.	2.		__/__/__ __:__ AM / PM

G. Date/Time Reported	H. Supervisor To Whom Incident Was Reported & Supervisor ID#	I. Supervisor Contact Number
: Am / / Pm		

J. Primary Language Spoken By Employee	K. Race Of The Injured Employee (ie: White, Black, Asian)	L. Ethnicity Of The Injured Employee (ie: Hispanic, Native American, Other)	M. Rate Of Pay At This Job
			$ _____Hourly $____ Weekly

N. Full Work Week Is	O. Last Paycheck Was	P. Length Of Service In Current Position	Q. Length Of Service In Occupation
____Hours _____Days	$ _____For ____Hours Or Days	____Years ____Months	_____Years ____Months

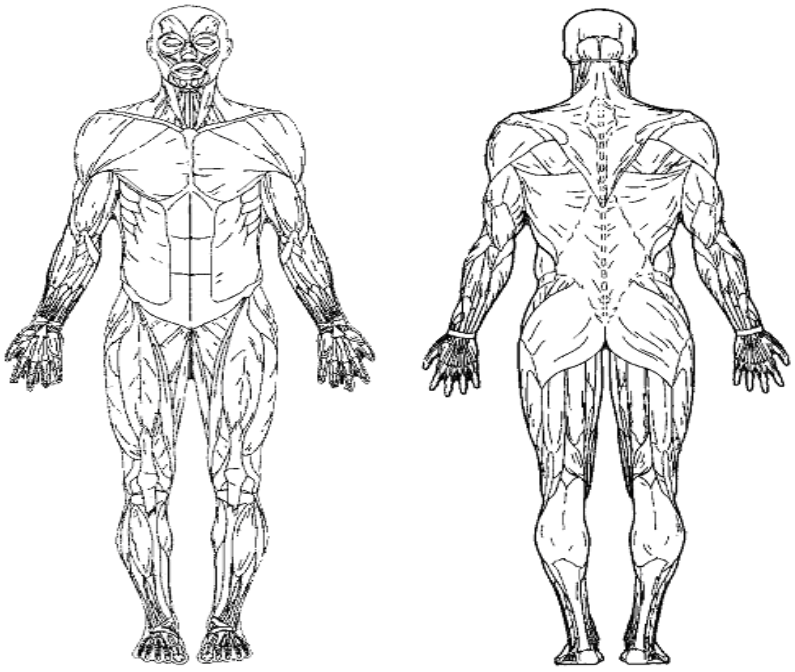
3. Medical Information

R. Medical Treatment Requested	S. Name, Address And Telephone Number Of Treating Facility
☐ Yes ☐ No	

4. Witness Information

T. Witness	U. Witness Contact Number(s)

Circle Injured Area(s)



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5. Employee Description Of How And Why Injury/Illness Occurred:

6. Nature Of Injury: (Example: Laceration, Burn, Fracture)

7. Cause Of Injury: (Example: Fall, Trip, Struck, Caught)

8. Additional Accident Information	
V. Address Where Injury/Exposure Occurred	W. Location At Time Of Incident
X. Activity At Time Of Incident	Y. Equipment Involved
Z. Other Items/Tools Involved	

AA. Name Of Person Completing Form	**BB. Title Of Person Completing Form**	**CC. Date Form Completed**
DD. Employee Signature	**EE. Date Form Signed**	**FF. Reference #**